Attachment 4. 19B

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

2a.

1. Outpatient Service - Shall be paid in accordance with Medicare principles of cost reimbursement as set out in the Medicare provider reimbursement manual in effect on October 1, 1982, except that the lower of cost or charges determination will be made separately and without consideration of inpatient cost or charges.

2. Independent Laboratory & X-Ray - Payment not to exceed usual and customary charges or the 75th percentile under Part B of Title XVIII, whichever is less.

Attachment 4.19B

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES - OTHER TYPES OF CARE

2.b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

Reimbursement for covered services shall consist of a single rate per visit as determined by the Medicare carrier pursuant to 42 CFR 405.2426 through 405.2429.

D3058293

SUPERSEDES TN NO. 87-1 6/30/88 12/5/88 7/1/88

AT-88-11
Effective 7/1/88

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES - OTHER TYPES OF CARE

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

Federally Qualified Health Centers will be reimbursed at 100 percent of reasonable allowable cost as determined from annual cost-reports.

D1100137

90-7
TN No. ____ DATE/RECEIPT 9-25-90
SUPERSEDES DATE/APPROVED 4-12-91
TN No. ____ DATE/EFFECTIVE 4-1-90

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES - OTHER TYPES OF CARE

---

3. Other Laboratory and X-Ray Services

(1) Independent Laboratory

Clinical diagnostic laboratory services shall be reimbursed at the lesser of:

(a) billed charges, or
(b) the Medicare fee schedule for clinical diagnostic laboratory services, not to exceed the national limitation established by the Consolidated Omnibus Budget Reconciliation Act of 1985.

Laboratory procedures not covered by the Medicare clinical diagnostic laboratory fee schedule shall be reimbursed at the lesser of:

(a) 100% of billed charges,or
(b) 85% of the usual and customary charges at the 50th percentile, or
(c) 85% of the statewide area prevailing charges at the 75th percentile, or
(d) 100% of the statewide maximum fee schedule, where usual and customary charges and area prevailing charges do not exist.

When usual and customary charges, area prevailing charges and the statewide maximum fee schedule do not exist, reimbursement is:

(a) 65% of billed charges.

Payment for any of the above will not exceed the amount that would have been paid on June 30, 1988.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES - OTHER TYPES OF CARE

(2) X-Ray

Reimbursement is not to exceed the lesser of:

(a) 100% of billed charges, or
(b) 85% of the usual and customary charges at the 50th percentile, or
(c) 85% of the statewide area prevailing charges at the 75th percentile, or
(d) 100% of the statewide maximum fee schedule, where usual and customary charges and area prevailing charges do not exist.

When usual and customary charges, area prevailing charges and the statewide maximum fee schedule do not exist, reimbursement is:

(a) 65% of billed charges.

Payment for any of the above will not exceed the amount that would have been paid on June 30, 1988.

D3038293

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES - OTHER TYPES OF CARE

4.b. Early and Periodic Screening, Diagnosis and Treatment

Maximum fees for the following are payable to screening providers.

Age	Screening	Physician Examination and Diagnosis
0 - 2 years	$12.00	$5.00
3 - 11 years	$14.00	$5.00
12 - 20 years	$18.00	$5.00

These fees are based on the cost of providing these services by EPSD&T screening providers. Payment for treatment services is made in accordance with allowable amount of payment to various providers which furnish such services. Reimbursement for screening does not include required immunizations. Reimbursement for the required immunizations will be the average wholesale price of the vaccine plus a $2.00 administration fee. Reimbursement for laboratory services provided under the EPSD&T program will be up to 90% of the current prevailing profile for Independent Laboratories and Private Physicians. Reimbursement of $11.00 is allowed for providing a developmental assessment.

Allowed EPSDT services that are not otherwise covered in the Plan will be reimbursed as follows:

a. Where available, Medicare rates will be utilized.

b. Where Medicare rates are not available, payment will be made in accordance with usual and customary fees. Usual and customary fees will be established using existing methods and practices for establishing such fees. Aggregate payments will not exceed amounts that could reasonably be estimated would have been paid under Medicare payment principles.

GW/D4030354

TN No. ~~90-7A~~ DATE/RECEIPT 6/26/91
SUPERSEDES DATE/APPROVED 9/23/91
TN No. 82-22 DATE/EFFECTIVE 4/1/90

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

4.4.C. Family Planning Services and Supplies - The rates reimbursed family planning clinics are based on the clinic cost per unit of service as determined by the Tennessee Department of Health and Environment's Bureau of Health Services Administration, Division of Family Planning Services in conjunction with the Bureau of Medicaid Administration.

Payments to other providers of family planning services are made in accordance with the methods of payment established for respective providers.

Payments will not exceed the upper limits pursuant to 42 CFR 447.321.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

6.a.
~~15.~~ Podiatrists Services - Payment is not to exceed the lesser of: the billed amount, a percentage of the usual and customary charge of each individual podiatrist or a percentage of the 75th percentile of the statewide prevailing charges for the base year used to calculate the profile.

Reimbursement shall be made at the rate in effect when service is provided.

6.b.
~~16.~~ Optometrists Services - payment is not to exceed the lesser of: the billed amount, a percentage of the usual and customary charge of each individual optometrist or a percentage of the 75th percentile of the statewide prevailing charges for the base year used to calculate the profile.

Reimbursement shall be made at the rate in effect when service is provided.

88-5 3/31/88 5/3/88 11/1/88

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

6d. Other practitioners' services

1. Physician Assistant

a. For services rendered at an SNF or ICF, reimbursement for a physician assistant service may not exceed 60 percent of the allowed amount for the comparable service rendered by a licensed physician.

b. Physician assistant services performed in a hospital (other than as an assistant-at-surgery) may not exceed 60 percent of the allowed amount for comparable services rendered by a licensed physician.

c. When a physician assistant performs services as an assistant-at-surgery, reimbursement may not exceed 60 percent of the allowed amount for a licensed physician assistant-at-surgery.

2. Certified Registered Nurse Anesthetist

a. Payment for services provided with medical direction will be the lesser of billed charges or forty-four percent (44%) of what would have been paid to a physician for similar services.

b. Payment for services provided without medical direction will be the lesser of billed charges or eighty percent (80%) of what would have been paid to a physician for similar services.

D1059166

TN No. 89-17 DATE/RECEIPT 9/15/89
SUPERSEDES DATE/APPROVED 8/29/89
TN No. NEW DATE/EFFECTIVE 7/1/89

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE TENNESSEE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES - OTHER TYPES OF CARE

7. Home Health Services

a. Nursing, Home Health Aide, Physical Therapy, Occupational Therapy, and Speech Evaluation services provided by a Home Health Agency

Reimbursement shall be the lesser of:

(1) Billed charges, or
(2) Reasonable costs according to Medicare principles of reimbursement and limits, or
(3) The median statewide cost per visit for each home health care service as determined each July 1. Each provider's most recent cost report on file as of April 1 of each year will be included in the determination of the median. Costs per visit will be trended from the midpoint of the state's fiscal year using the forecasted percent increase in the home health agency market basket as published in the federal register.

Interim payments are based on previous year's costs and year-end cost settlements are made for each agency. In no event shall reimbursement exceed the per visit limits established by Medicare.

b. Medical Supplies

(1) When provided by a Home Health Agency, reimbursement shall be the lesser of:

(a) billed charges; or
(b) 100% of the 75th percentile of Medicare prevailing charges in effect as of June 30, 1988; or
(c) where there are no Medicare prevailing charges, an amount established under a State fee schedule in effect June 30, 1988; or
(d) The lowest bid price for the equipment, device, appliance or supply resulting from advertisements requesting bids from qualified vendors to furnish these items.

All payments for medical supplies are deemed payment in full and are excluded from the cost reports.

(2) When provided by other providers, reimbursement shall be the lesser of:

(a) billed charges; or
(b) 100% of the 75th percentile of Medicare prevailing charges; or